

Last reviewed: March 2017

Intervention website: <u>https://www.lifeskillstraining.com/</u>

# GUIDEBOOK INTERVENTION INFORMATION SHEET

### Advanced LifeSkills Training

Please note that in the 'Intervention summary' table below, 'child age', 'level of need', and 'race and ethnicities' information is **as evaluated in studies**. Information in other fields describes the intervention as **offered/supported by the intervention provider**.

Intervention summary			
Description	Advanced LifeSkills Training is a school-based substance misuse prevention intervention for all children aged between 11 and 14 years old. It is delivered by teachers, social workers, or youth workers to groups of children in the classroom for 36 sessions. It teaches children and young people personal self-management skills, social skills, and strategies for resisting tobacco, alcohol, and drugs.		
Evidence rating	3+		
Cost rating	1		
Child outcomes	<ul> <li>Preventing substance use</li> <li>Reduced smoking</li> <li>Reduced alcohol use</li> <li>Reduced drug use.</li> </ul>		
<b>Child age</b> (population characteristic)	12 to 13 years old		
<b>Level of need</b> (population characteristic)	Universal		

#### Foundations Guidebook – Intervention information sheet

Visit the Foundations Guidebook | <u>www.foundations.org.uk/guidebook</u>

Intervention summary			
<b>Race and</b> <b>ethnicities</b> (population characteristic)	<ul> <li>African American</li> <li>Asian</li> <li>Hispanic</li> <li>Mixed ethnic background</li> <li>White.</li> </ul>		
<b>Type</b> (model characteristic)	Group		
<b>Setting</b> (model characteristic)	Secondary school		
<b>Workforce</b> (model characteristic)	Teachers, social workers, or youth workers		
UK available?	Yes		
UK tested?	No		

## Model description

Advanced LifeSkills Training (LST) is a school-based substance misuse prevention intervention designed to help young people avoid tobacco, alcohol, and drug use.

Advanced LifeSkills Training is delivered to classrooms of children or young people by teachers, social workers, or youth workers. The curriculum teaches children and young people personal self-management skills, social skills, and strategies for resisting tobacco, alcohol, and drugs.

Advanced LST is delivered in 36 sessions of one hour's duration each by one teacher, social worker, or youth worker to classrooms of young people. 17 of these sessions are delivered when the young people are between 11 and 12 years old (level 1). 12 sessions are delivered when they are between 12 and 13 years old (level 2), and a further seven sessions are delivered when they are between 13 and 14 years old (level 3) – these act as booster sessions so that key concepts and skills are reinforced and developed over time.

The curriculum is taught with a variety of techniques to include facilitation, coaching, assessment, and behavioural rehearsal which are proven training methods. Young people receive a copy of their own workbook called the 'LifeSkills Magazine' which is full of activities and exercises which reinforce what they have learned in class. There are also letters available as part of the intervention to send home to parents so they can reinforce the techniques being used.

### **Target population**

Age of child	11 to 14 years old	
Target population	Students aged 11 to 14 old.	

Please note that the information in this section on target population is as **offered/supported by the intervention provider**.

## Theory of change

Why		Who	How	What		
Science-based assumption	Science-based assumption	Science-based assumption	Intervention	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Substance misuse often occurs in young adulthood, with early initiation in adolescence increasing the risk of long-term misuse.	Strong self- management skills protect children and young people from misusing tobacco, alcohol, and illegal drugs.	All young people aged 11 to 14 years old.	LST teaches young people self- management skills such as decision- making and dealing with stress, social skills such as effective communication, and strategies for resisting peer pressure such as assertiveness.	<ul> <li>Young people have better awareness about the misconceptions associated with drugs, tobacco, and alcohol.</li> <li>Young people are also better able to communicate positively with others.</li> </ul>	<ul> <li>Improved peer relationships</li> <li>Increased resistance to risky behaviours</li> <li>Improved school performance.</li> </ul>	Reduced risk- taking behaviours and substance misuse.

## **Implementation requirements**

Who is eligible?	Students aged 11 to 14 years old				
How is it delivered?	Advanced LifeSkills Training is delivered in 36 sessions of one hours' duration each by one teacher, social worker, or youth worker, to classrooms of young people.				
	17 of these sessions are delivered when the young people are aged between 12 to 12 years old. 12 sessions are delivered when they are aged between 12 and 13 years old, and a further seven booster sessions are delivered when they are aged between 13 and 14 years old.				
What happens during the intervention?	The curriculum teaches children and young people personal self-management skills, social skills, and strategies for resisting tobacco, alcohol, and drugs.				
	The curriculum is taught with a variety of techniques to include facilitation, coaching, assessment, and behavioural rehearsal which are proven training methods.				
	Young people receive a copy of their own workbook called the 'LifeSkills Magazine' which is full of activities and exercises which reinforce what they have learned in class.				
	There are also letters available as part of the intervention to send home to parents so they can reinforce the techniques being used.				
Who can deliver it?	The practitioner who delivers this intervention is a classroom teacher (or youth/social worker).				
What are the training requirements?	The practitioners have 14 hours of intervention training. Booster training of practitioners is recommended.				
How are practitioners supervised?	It is recommended that practitioners are supervised by one intervention developer supervisor.				
What are the systems for maintaining fidelity?	<ul> <li>Intervention fidelity is maintained through the following processes:</li> <li>Training manual</li> <li>Other printed material</li> <li>Fidelity monitoring</li> <li>Huddle (collaboration software) facilitates discussions on the intervention between intervention facilitators</li> <li>In-class coaching support.</li> </ul>				



## **Implementation requirements (Cont.)**

Is there a licensing requirement?	Yes		
*Contact details	Contact person: Lauren Spiers Organisation: Barnardos Email addross: Lauren spiers@barnardos org.uk		
	<ul> <li>Websites: <u>https://www.lifeskillstraining.com/</u> <u>www.barnardos.org.uk/lifeskills</u> <u>http://www.episcenter.psu.edu/ebp/lifeskills</u></li> <li>*Please note that this information may not be up to date. In this case, please visit the listed intervention website for up to date contact details.</li> </ul>		

## Evidence summary

Advanced LifeSkills Training's most rigorous evidence comes from three RCTs which were conducted in the United States.

This study identified statistically significant reductions in risk-taking, alcohol use, drug use, smoking, and alcohol-related problems.

Advanced LifeSkills Training can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome, as well as at least one more RCT or QED.

Child outcomes					
Outcome	Improvement index	Study			
Reduced risk- taking	+7	8.5-point improvement on the Eysenck Personality Inventory (self-report). Long-term: A year later	1a		
Reduced drunkenness frequency	+4	0.09-point improvement on the 9-point drunkenness frequency response scale (study 1a) Long-term: A year later 0.13-point improvement on a single-item self-report measure of drunkenness frequency (study 1b) Long-term: 9 years later	1a, 2b		
Reduced smoking frequency	+5	0.21-point improvement on the 9-point smoking frequency response scale (study 1a) Long-term: A year later 0.17-point improvement on a single-item self-report measure of smoking frequency (study 2b) Long-term: 9 years later	1a, 2b		
Reduced smoking quantity	+7	0.13-point improvement on the 11-point smoking index Long-term: a year later	1a		
Reduced drinking frequency	+7	0.22-point improvement on the 6-point 'amount consumed per occasion' scale Long-term: A year later	1a		



Reduced drinking quantity	+7	0.17-point improvement on the 9-point drinking quantity response scale Long-term: a year later	1a
Reduced frequency of inhalant use	+3	0.05-point improvement on the 9-point inhalant use frequency response scale (self-report) Long-term: a year later	1a
Reduced current polydrug use	+5	0.09-point improvement on the current polydrug usage score (self-report) Long-term: a year later	1a
Reduced lifetime polydrug use	+7	0.18-point improvement on the lifetime polydrug usage score Long-term: a year later	1a
Reduced binge drinking	+21	<ul> <li>2.5-percentage point reduction in proportion of participants who are binge drinkers (measured using a one-item self- report measure assessing how much a participant drinks each time they drink) (12-month follow up)</li> <li>Long-term: a year later</li> <li>3-percentage point reduction in proportion of participants who are binge drinkers (measured using a one-item self- report measure assessing how much a participant drinks each time they drink)</li> </ul>	1b
De local		Long-term: 2 years later	
substance initiation	+7	C.18-point improvement on the Substance Initiation Index Long-term: 5 years later	2a
Reduced alcohol- related problems	+5	0.06-point improvement on Rutgers2bAlcohol Problem Index2bLong-term: 9 years later	

### Search and review

	Number of studies
Identified in search	9
Studies reviewed	2
Meeting the L2 threshold	0
Meeting the L3 threshold	2
Contributing to the L4 threshold	0
Ineligible	7

## Individual study summary: Study 1a

Study 1a	
Study design	RCT
Country	United States
Sample characteristics	5,222 children with a mean age of 12.9 from 29 New York City schools.
Race, ethnicities, and nationalities	<ul> <li>61% African American</li> <li>22% Hispanic</li> <li>6% Asian</li> <li>6% White</li> <li>5% Mixed or other ethnic backgrounds.</li> </ul>
Population risk factors	<ul> <li>The sample was predominantly composed of ethnic minority groups and was economically disadvantaged (62% free school lunch)</li> <li>Approximately half (54%) of students lived in a two-parent household and 36% lived in mother-only households.</li> </ul>
Timing	<ul> <li>Baseline</li> <li>Three-month follow-up</li> <li>12-month follow-up.</li> </ul>

Study 1a	
Child outcomes	<ul> <li>Reduced smoking use (youth self-report)</li> <li>Reduced alcohol use (youth self-report)</li> <li>Drunkenness (youth self-report)</li> <li>Reduced drug use (youth self-report)</li> <li>Reduced current polydrug use (youth self-report)</li> <li>Reduced lifetime polydrug use (youth self-report).</li> </ul>
Other outcomes	None
Study Rating	3
Citation	Botvin, G. J., Griffin, K. W., Diaz, T. & Ifill-Williams, M. (2001) Drug abuse prevention among minority adolescents: Posttest and one-year follow-up of a school-based preventive intervention. <i>Prevention Science</i> . 2 (1), 1–13.

### **Brief summary**

#### **Population characteristics**

The sample consisted of 5,222 children from 29 schools in New York, US. Of the participants, 53% were girls and 47% boys, with a mean age of 12.9 years old. The sample was predominantly composed of individuals from minority ethnic groups and were economically disadvantaged (62% free school lunch). Most participants were African American (61%), 22% Hispanic, 6% Asian, 6% White, and 5% Mixed or other ethnic background. Approximately half (54%) of students lived in a two-parent household and 36% lived in mother-only households.

#### Study design

16 schools were randomly allocated to receive the Advanced LifeSkills Training intervention and 13 were allocated to a business-as-usual control group. A blocked randomised design was used. Prior to randomisation, schools were surveyed and divided into high, medium, or low smoking prevalence and then were randomised from within these groups.

#### Measurement

Measures were completed at baseline, three months, and 12 months post-intervention.

**Youth report** measures included: self-report questionnaires on substance use, normative expectations, and drug attitudes and knowledge; the Coping Assessment Battery; the Gambrill and Richey Assertion Inventory; and the Eysenck Personality Inventory.



#### **Study retention**

69% (N=3,621) of children participated in post-intervention assessment, representing 2,144 intervention group participants and 1,477 control group participants.

#### **Results**

#### Data-analytic approach

Generalised linear models, ANCOVA and generalised estimating equations independent method (GEE) models were used to estimate the intervention's effects on the intended outcomes. Covariates for all analyses were gender, race, percentage intervention completed, free lunch, and baseline substance use.

#### Findings

Children in the intervention group showed statistically significant reductions in drunkenness frequency and lifetime polydrug use at post-test, and statistically significant reductions in risk taking, drunkenness frequency, smoking frequency and quantity, drinking frequency and quantity, frequency of inhalant use, and current and lifetime polydrug use at 12-months post-intervention.

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point		
	Child outcomes						
Smoking frequency	Smoking frequency measure (youth self-report)	Not reported	No	3,621	Three-month post-intervention		
Smoking frequency	Smoking frequency measure (youth self-report)	Not reported	Yes	3,621	One-year post- intervention		
Smoking quantity	Smoking quantity measure (youth self-report)	Not reported	No	3,621	Three-month post-intervention		
Smoking quantity	Smoking quantity measure (youth self-report)	Not reported	Yes	3,621	One-year post- intervention		

#### Study 1a: Outcomes table



Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Drinking frequency	Drinking frequency measure (youth self-report)	Not reported	No	3,621	Three-month post-intervention
Drinking frequency	Drinking frequency measure (youth self-report)	Not reported	Yes	3,621	One-year post- intervention
Drinking quantity	Drinking quantity item measure (youth self-report)	Not reported	No	3,621	Three-month post-intervention
Drinking quantity	Drinking quantity item measure (youth self-report)	Not reported	Yes	3,621	One-year post- intervention
Drunkenness frequency	Drunkenness frequency item measure (youth self-report)	Not reported	Yes	3,621	Three-month post-intervention
Drunkenness frequency	Drunkenness frequency item measure (youth self-report)	Not reported	Yes	3,621	One-year post- intervention
Marijuana frequency	Marijuana frequency item measure (youth self-report)	Not reported	No	3,621	One-year post- intervention
Inhalant frequency	Inhalant frequency item measure (youth self-report)	Not reported	Yes	3,621	One-year post- intervention



Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Lifetime polydrug use	Smoking, drinking, marijuana, and inhalant use frequency items (youth self-report)	Not reported	Yes	3,621	Three-month post-intervention
Lifetime polydrug use	Smoking, drinking, marijuana, and inhalant use frequency items (youth self-report)	Not reported	Yes	3,621	One-year post- intervention
Current polydrug use	Smoking, drinking, marijuana, and inhalant use frequency items (youth self-report)	Not reported	No	3,621	Three-month post-intervention
Current polydrug use	Smoking, drinking, marijuana, and inhalant use frequency items (youth self-report)	Not reported	Yes	3,621	One-year post- intervention
Risk-taking	Eysenck Personality Inventory (youth self-report)	Not reported	Yes	3,621	One-year post- intervention

## Individual study summary: Study 1b

Study 1b			
Study design	RCT		
Country	United States		
Sample characteristics	3,041 children with a mean age of 12.9 years, from 29 schools in New York city.		
Race, ethnicities, and nationalities	<ul> <li>61% African American</li> <li>22% Hispanic</li> <li>6% Asian</li> <li>6% White</li> <li>5% Mixed or other ethnic backgrounds.</li> </ul>		
Population risk factors	The sample was predominantly composed of ethnic minority groups and was economically disadvantaged (62% free school lunch). Approximately half (55%) of students lived in a two-parent household and 35% lived in mother-only households.		
Timing	Two-year follow-up		
Child outcomes	Reduced binge drinking (youth self-report)		
Other outcomes	None		
Study Rating	3		
<b>Citation</b> Botvin, G. J., Griffin, K. W., Diaz, T. & Ifill-Williams, M. (2001 binge drinking during early adolescence: One- and two-year for school-based preventive intervention. <i>Psychology of Addictive</i> 15 (4), 360–365.			

### **Brief summary**

#### **Population characteristics**

The sample consisted of 5,222 children from 29 schools in New York, US. Of the participants, 53% were girls and 47% boys, with a mean age of 12.9 years old. The sample was predominantly composed of individuals from minority ethnic groups and were economically disadvantaged (62% free school lunch). Most participants were African American (61%), 22% Hispanic, 6% Asian, 6% White, and 5% Mixed or other ethnic background. Approximately half (54%) of students lived in a two-parent household and 36% lived in mother-only households.

#### Study design

16 schools were randomly allocated to receive the Advanced LifeSkills Training intervention and 13 were allocated to a business-as-usual control group. A blocked randomised design was used. Prior to randomisation, schools were surveyed and divided into high, medium, or low smoking prevalence and then were randomised from within these groups.

#### Measurement

- Measures were completed at baseline, one year, and two years post-intervention.
- Youth report measures included questionnaires on alcohol and drug use.

#### **Study retention**

58% (3,041) of students participated in two-year follow-up assessments, representing 1,713 intervention participants and 1,328 control participants.

#### Results

#### Data-analytic approach

Data was analysed using chi-square tests, generalised linear models, ANOVA, and logistic regression, with adjustments for ICCs, to estimate the intervention's effects on the intended outcomes.

#### Findings

Children in the intervention group showed statistically significant reductions in binge drinking at two years post-intervention.

#### Study 1b: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point	
Child outcomes						
Binge drinking	Dichotomised version of a six- point scale assessing alcohol consumed per drinking occasion (youth self-report)	0.40 (OR)	Yes	2,982	Two years post- intervention	

## Individual study summary: Study 2a

Study 2a	
Study design	Cluster RCT
Country	United States
Sample characteristics	1,667 children aged between 12 and 13 years old.
Race, ethnicities, and nationalities	96% White
Population risk factors	Participants were predominately from rural areas.
Timing	<ul><li>Baseline</li><li>Five-year follow-up.</li></ul>
Child outcomes	Reduced substance initiation (youth self-report)
Other outcomes	None
Study Rating	3

Study 2a	
Citation	Spoth, R. L., Randall, G. K., Trudeau, L., Shin, C. & Redmond, C. (2008) Substance use outcomes 5 <sup>1</sup> / <sub>2</sub> years past baseline for partnership-based, family-school preventive interventions. <i>Drug and Alcohol Dependence</i> . 96 (1–2), 57–68.

### **Brief summary**

#### **Population characteristics**

The sample were children aged between 12 and 13 years old from 36 schools in rural northeast Iowa, US. The participants were predominantly White (96%) from economically disadvantaged families and recruited from rural areas. Participants were 53% male and recruited from communities with a high proportion of students qualifying for free or reduced-cost lunch.

#### Study design

36 schools were divided into 12 matched sets of three based on school-level risk measures from a prospective telephone survey of randomly selected parents. Within each set, schools were randomly assigned to one of three experimental conditions. Schools were randomly allocated using a blocked randomisation approach to one of three conditions:

- 1. 12 were allocated to the combined Life Skills Training (LST) plus Strengthening Families Program (SFP) 10-14 intervention
- 2. 12 were allocated to LST-only intervention
- 3. 12 were allocated to a minimal-contact control condition in which participants received only informational leaflets on teen development.

The control group received only informational leaflets about teen development mailed to parents, with no additional intervention or follow-up components.

#### Measurement

- Assessments were completed at baseline and five years post-intervention.
- **Youth report** measures included questionnaires on substance initiation and substance use.

#### **Study retention**

82% of participants took part in post-intervention assessment, representing 1,172 of intervention participants and 496 of control participants.

74% of participants took part in post-intervention assessment, representing 878 of intervention participants and 347 of control participants.

#### Results

#### Data-analytic approach

Hierarchical linear modelling and multilevel ANCOVA were used to estimate the intervention's effects on the intended outcomes. An intent-to-treat design was also used and missing data was handled using full-information maximum likelihood estimation (FIML).

#### Findings

Children in the intervention group showed statistically significant reductions in reduced substance initiation at five years post-intervention.

#### Statistical Number of Measurement **Effect size** Outcome Measure significance participants time point **Child outcomes** Substance Substance Initiation Not reported Yes 1,621 Five years postinitiation intervention Index (youth selfreport) Frequency of Substance use Not reported No 1,237 Five years postintervention substance frequency measures (youth self-report) use: alcohol use, cigarette use, drunkenness and marijuana use Polysubstance Poly-substance use Not reported No Five years post-1,237 index (youth selfintervention use report) Advanced polysubstance use index (youth self-report)

#### Study 2a: Outcomes table

## Individual study summary: Study 2b

Study 2b				
Study design	Cluster RCT			
Country	United States			
Sample characteristics	1,667 children aged between 12 and 13 years old from 36 schools.			
Race, ethnicities, and nationalities	99% White			
Population risk factors	The sample was predominately recruited from rural areas and focused on a higher-risk subsample of students who had initiated use of two or more substances by the time of pretesting.			
Timing	<ul><li>Baseline</li><li>Nine-year follow-up.</li></ul>			
Child outcomes	<ul> <li>Reduced drunkenness frequency (youth self-report)</li> <li>Reduced smoking frequency (youth self-report)</li> <li>Reduced alcohol-related problems (youth self-report).</li> </ul>			
Other outcomes	None			
Study Rating	3			
Citation	Spoth, R., Trudeau, L., Redmond, C. & Shin, C. (2014) Replication RCT of early universal prevention effects on young adult substance misuse. <i>Journal of Consulting and Clinical Psychology</i> . 82 (6), 949–96.			

### **Brief summary**

#### **Population characteristics**

The sample were children aged between 12 and 13 years, from economically disadvantaged families, recruited from 36 schools in rural northeast Iowa, US. Participants were predominantly White (99%). The sample included both lower- and higher-risk students, with 20% of participants classified as higher risk due to substance use initiation at baseline.

#### Study design

36 schools were divided into 12 matched sets of three based on school-level risk measures from a prospective telephone survey of randomly selected parents. Within each set, schools were randomly assigned to one of three experimental conditions. Schools were randomly allocated using a blocked randomisation approach to one of three conditions:

- 1. 12 were allocated to the combined Life Skills Training (LST) plus Strengthening Families Program (SFP) 10-14 intervention
- 2. 12 were allocated to LST-only intervention
- 3. 12 were allocated to a minimal-contact control condition in which participants received only informational leaflets on teen development.

The control group received only informational leaflets about teen development mailed to parents, with no additional intervention or follow-up components.

#### Measurement

- Assessments were completed at baseline and nine years post-intervention.
- **Youth report** measures included questionnaires on substance initiation, drunkenness frequency, cigarette use, illicit substance use, and a modified form of the Rutgers Alcohol Problems Index.

#### **Study retention**

84.6% (1,410) of youth participated in the nine-year follow-up assessment. The exact sample size for each condition was not reported.

#### Results

#### Data-analytic approach

Hierarchical latent growth curve modelling with two-step modelling strategies were used to estimate the intervention's effects on the intended outcomes. Missing data was handled using full-information maximum likelihood estimation (FIML).

#### Findings

Children in the intervention group showed statistically significant reductions in reduced drunkenness frequency, cigarette use, and alcohol-related problems at nine years post-intervention.

#### Study 2b: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point	
Child outcomes						
Drunkenness frequency	Adapted from the Monitoring the Future study (youth self-report)	Not provided	Yes	1,061	Nine years post- intervention	
Alcohol- related problems	Adapted from the Rutgers Alcohol Problems Index (youth self-report)	Not provided	Yes	1,061	Nine years post- intervention	
Cigarette use	Single item scale measuring frequency (youth self-report)	Not provided	Yes	1,061	Nine years post- intervention	
Illicit substance use frequency	Nine open-ended items (youth self- report)	Not provided	No	1,061	Nine years post- intervention	

## Other studies

The following studies were identified for this intervention but did not count towards the intervention's overall evidence rating. An intervention receives the same rating as its most robust study or studies.

Botvin, G. J., Griffin, K. W. & Williams, C. (2015) Preventing daily substance use among high school students using a cognitive-behavioral competence enhancement approach. *World Journal of Preventive Medicine*. 3 (3), 48–53.

Botvin, G. J., Griffin, K. W. & Nichols, T. D. (2006).Preventing youth violence and delinquency through a universal school-based prevention approach. *Prevention Science*. 7 (4), 403–408.

Botvin, G. J., Epstein, J. A., Baker, E., Diaz, T. & Ifill-Williams, M. (1997) School-based drug abuse prevention with inner-city minority youth. *Journal of Child & Adolescent Substance Abuse*. 6 (1), 5–19.



Crowley, D. M., Jones, D. E., Coffman, D. L. & Greenberg, M. T. (2014) Can we build an efficient response to the prescription drug abuse epidemic? Assessing the cost effectiveness of universal prevention in the PROSPER trial. *Preventive Medicine*. 62, 71–77.

MacKillop, J., Ryabchenko, K. A. & Lisman, S. A. (2006) Life skills training outcomes and potential mechanisms in a community implementation: A preliminary investigation. *Substance Use & Misuse*. 41 (14), 1921–1935.

Sneddon, H. (2015) *LifeSkills substance misuse prevention programme: Evaluation of implementation and outcomes in the UK. Full report.* 

Spoth, R., Trudeau, L., Shin, C., Ralston, E., Redmond, C., Greenberg, M. & Feinberg, M. (2013) Longitudinal effects of universal preventive intervention on prescription drug misuse: Three randomized controlled trials with late adolescents and young adults. *American Journal of Public Health*. 103 (4), 665–672.

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**Note on provider involvement:** This provider has agreed to Foundations' terms of reference (or the Early Intervention Foundation's terms of reference), and the assessment has been conducted and published with the full cooperation of the intervention provider.